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Chemist&Druggist
The Newsweekly for Pharmacy

C&D

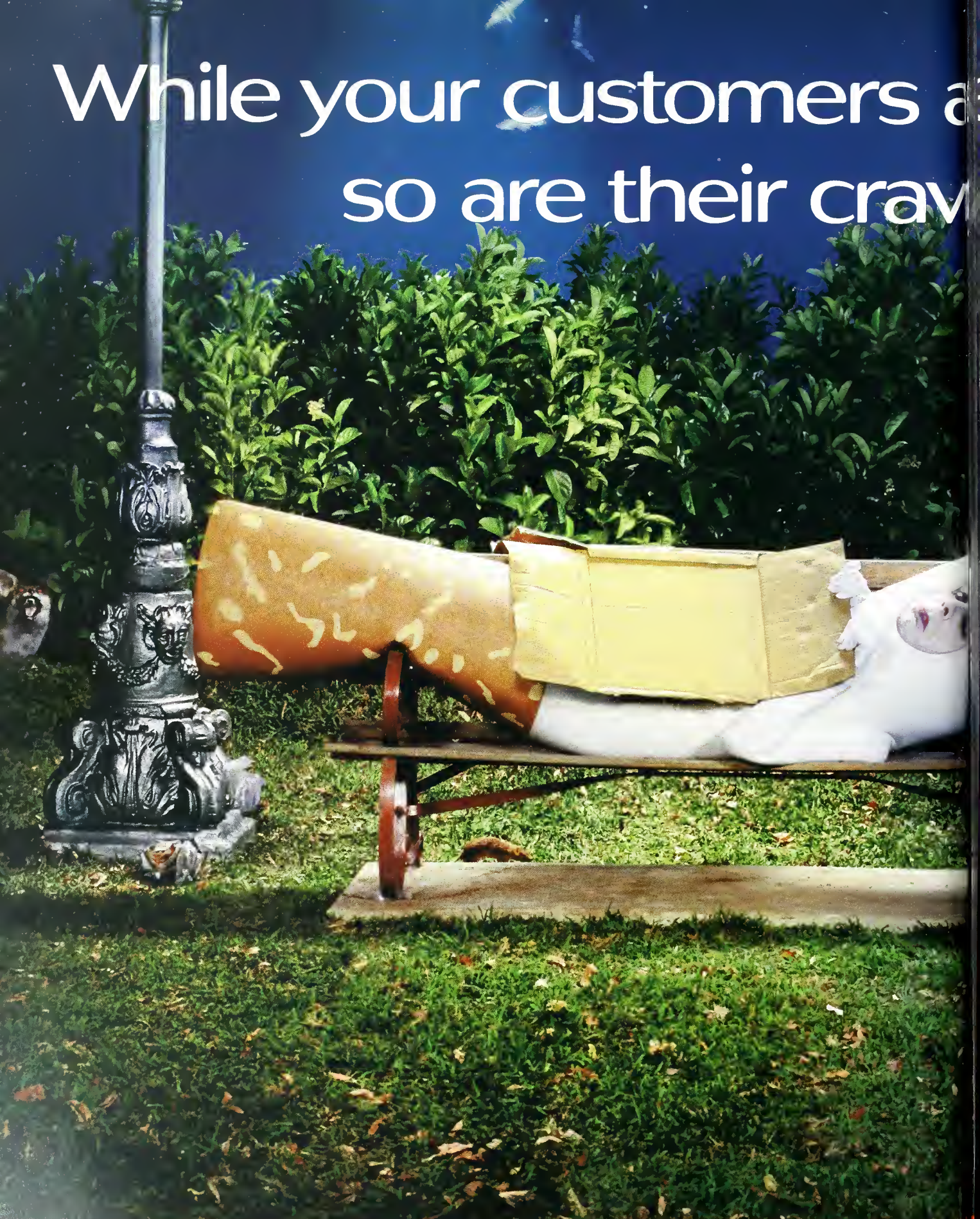
11 January 2003

RPSGB: skill mix plans need more resources

PSNC: keep the pharmacist on the premises

The case for opening out NRT usage

How much do you know about rave drugs?



Abbreviated Prescribing Information. Nicorette Patch.
Presentation: Transdermal delivery system available in 3 sizes (30, 20 and 10cm²) releasing 15mg, 10mg and 5mg of nicotine respectively over 16 hours. **Indications:** Nicotine dependence and symptom relief in smoking cessation. **Dosage & Administration:** Nicorette patches should not be used concurrently with other nicotine products and patients must stop smoking completely when starting the treatment. The recommended treatment programme should occupy 3 months. One Nicorette patch should be applied to a dry, non-hairy area of the skin on the hip, upper arm or chest in the morning and removed at bedtime. Application should be limited to 16 hours within any 24-hour period. Patients are recommended to commence with one 15 mg patch daily for the first 8 weeks. Patients who have remained abstinent should then be supported through a weaning period, consisting of one 10mg patch daily for 2 weeks followed by one 5mg patch daily for a further two weeks. Patients should be reviewed at 3 months and if abstinence has not been achieved, further courses of treatment may be recommended if it is considered that the patient would benefit. Not for use by persons under 18 except under advice from a doctor. **Precautions:** Peptic ulcer, angina pectoris, recent myocardial infarction, serious

That's why Nicorette Patch is **specifically designed** to be taken off at bedtime.

Nicorette Patch is specifically designed to be taken off at bedtime, so the body gets a break. It's a discreet, easy-to-use, once-a-day dose available in three strengths so your customers can

gradually reduce their nicotine intake. The new Nicorette Patch TV campaign featuring the benefit of "the patch you take off at night" starts soon.

So give your customers Nicorette Patch and help them beat cigarettes one at a time.

You're twice as likely to succeed* with

nicorette®

patch

ac arrhythmias, systemic hypertension, peripheral vascular disease, diabete[s] mellitu[s] rthyroidism, phaeochromocytoma, recent cerebrovascular accident, [illegible] ralised dermatological disorders. **Contra-indications:** Pregnancy & Lactatio[n] nt cannot give up smoking without NRT then a risk benefit assessment should be [illegible] smokers, known hypersensitivity to nicotine or component of the patch. **Spe[cial] ings:** Rarely dependence. Erythema may occur. If severe or persistent, disco[ntinue] nent. **Adverse Effects:** Application site reactions (e.g. erythema and itching), headache ea, dizziness, palpitations, dyspepsia and myalgia. **Pharmaceutical Precaution[s]**

Do not store above 30°C **Legal Category:** GSL **Package Quantities & Cost** (all trade prices correct at time of printing) Cartons containing Nicorette patches in single sachets in the following quantities: Nicorette Patch 15mg (PL00032/0294) – packs of 7 (£9 07) Nicorette Patch 10mg (PL00032/0293) – packs of 7 (£9 07) Nicorette Patch 5mg (PL00032/0292) – packs of 7 (£9 07) **PL Holder:** Pharmacia Limited, Davy Avenue, Milton Keynes, MK5 8PH, UK. Tel 01908 661101 **Date of Preparation:** October 2002

*Compared to willpower alone

P8593/10/02

Are you an independent community pharmacist?

Do you and your team deserve recognition?

Do your patients recognise you?

Then enter

'Engaging the Patient'

The 1st Pharmacia-PHOENIX Pharmacy Practice Award

'Pharmacy in the Future' envisages a role for pharmacists a world away from the dispensary. At Pharmacia and PHOENIX we know it's already happening, and we want to recognise the contribution community pharmacies are making to patient care.

If you're a community pharmacist who has led an innovative project to shape care around the patient, the you could be the first winner of this prestigious award.

Our judging panel, chaired by Patrick Grice of the C&D magazine, will choose three regional winners, Scotland; North, Midlands and Wales; and South. The winners wi receive a plaque for their pharmacy and an individual trophy for all staff members involved in the project.

The regional winners will go forward to the National Fina to be held at a country house hotel in April 2003. They will present their initiative to the judges, and a national winner will be announced at a presentation dinner. All expenses, including locums, will be covered. Help will be available to formulate presentations, and the nationa winner will receive £1500.

For more details and an entry form, please call Judith Lovell, Tel: 01928 750660

PHARMACIA

PHOENIX
Healthcare Distribution Limited

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POLICY

Skill mix changes need resources

The RPSGB has told the Government that any changes that may result from the skill mix proposals will need suitable resources.

In a strongly worded opening to its reply to the Department of Health discussion paper, the Society says: "In writing this response, it has been assumed the Government has realised that future developments, if they are to be sustainable, need to be adequately resourced."

In particular, the Society would like to see community pharmacy given better access to NHS resources for training and development.

"An important point is the need for recognition that the community sector, as well as the hospital sector, is a provider of services to the NHS, and it is necessary, therefore, to make similar resources available for the training and development of staff."

Among the requests made by the Society in its response to *Pharmacy workforce in the new NHS* are that:

- priority be given to establishing a firm time table for independent prescribing
- links should be strengthened with the Workforce Development Confederations "and simplifying access to their resources is a must"
- the Improving Working Lives standard of making personal and professional development training opportunities accessible and open to all staff should be made inclusive of all staff delivering NHS services
- there should be an integrated 'joined up' strategy for capitalising on IT developments to meet future information needs.

When considering the proposals over pharmacy supervision, the Society says that models derived from hospital practice, whereby technicians have taken on some responsibilities, cannot be directly translated into the community pharmacy setting, because of both resource and legislative reasons.

"The need to ensure effective supervision will have to be met in a way that reflects the particular operating environment," says the response. "This could mean that in reality, moving away from the need to have direct supervision by a pharmacist in some environments, and in particular the typical community pharmacy setting, may not be possible."

Instead, the Society says that the high standards of professional service developed over the years have become an expectation of the public.

"It is a concern that in the future the public may think that this level of service could be adversely affected, particularly in the community setting, by pharmacists being absent for periods of time while the pharmacy is open."

It also points out that current pharmacy technician training to S/NVQ Level 3, while seen as a minimum requirement, does not contain any training or competency assessment for accuracy checking. However, it suggests that there could be a system for regulating pharmacy support staff at different levels.

IT

PPA website hosts drug dictionary

A downloadable version of the *Primary Care Drug Dictionary* is now available from the Prescription Pricing Authority's website.

The dictionary, which currently includes 99 per cent of products prescribed, is now being trialled by some GP and pharmacy system suppliers with the aim of rolling it out nationally later in the year.

The *PCDD* is intended to be used as a cornerstone for ETP, the automation of business processes within the PPA, and ultimately for use in primary care across the NHS in England, says the PPA (*C&D, December 7 2002, p12*).

The range of products that the dictionary will reference include:

- drugs which are prescribable and reimbursable within primary care
- products that are included in Schedule 10 of the NHS (General Medical Services) Regulations
- appliances and reagents that are listed in the NHS *Drug Tariff* for England and Wales.

For more information:

http://www.ppa.org.uk/systems/pcdd_intro.htm

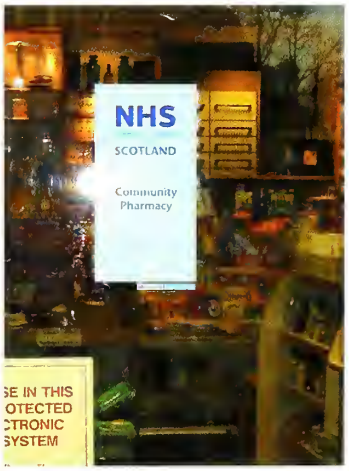
SCOTLAND

'Inclusive' NHS logo for pharmacies

Pharmacies in Scotland have each been sent a window sticker and an A4 card to raise public awareness of community pharmacies' role in providing NHS services.

A joint letter was sent out from the Scottish Executive's Department of Health and the Pharmaceutical General Council asking contractors to use the material, which was proposed in the Scottish pharmacy strategy published last February. A Scottish Consumer Council survey late last year found that as few as half of respondents recognised their pharmacist as part of the NHS.

SPGC chairman Frank Owens commented: "We are trying to get every pharmacy contractor in Scotland to get the logo out there and on the door.



"Pharmacies are strategically located, both in our high streets and in the heart of many of our local communities. In some areas, they are the only NHS primary care facility available to the public.

"If community pharmacists are to be successful in implementing the Scottish Executive's pharmacy strategy, *The Right Medicine*, then we need to ensure patients recognise our role as key members of the primary care team."

PROFESSION

Co-op to pilot checking technicians this year

United Co-op Pharmacy Group is preparing to pilot technician checking later this year, thus responding to the Government's skill mix document *Pharmacy Workforce in the new NHS*, which was announced at last year's BPC (*C&D September 28 and October 5, 2002*).

While the timing and size of the pilot are to be determined, Nia Evans, United's superintendent pharmacist, said: "Anything with the potential to free pharmacists' time to improve their role and professional standing and add value for our customers must surely be worthy of our commitment."

In preparation for these new tasks and the potential requirement for accreditation of pharmacy technicians and pharmacy assistants by 2005, United has launched new training packages for pharmacy support staff.

The modular training courses, which are to either NVQ level 2 (dispensing assistants) or NVQ level 3 (dispensing technicians), consist of a combination of workbook and practical exercises.

They are designed to take around one year to complete, and the required time commitment is estimated to be an average of one hour per module. Participants are expected to complete two modules a month but some flexibility is built in. A new grading system for staff working for the 300-strong pharmacy chain, introduced at the same time, now includes an incremental benefit for each course passed.

"Ensuring we have well trained, self-motivated support staff will drive up standards and give pharmacy staff a clear and positive career path," explained Ms Evans.

The South East Antrim Locality Pharmacy Group has launched a Medicines Waste Awareness Campaign in the Newtownabbey, Carrickfergus and Larne area. The Northern Health and Social Services Board is funding the campaign, which runs until the end of the month. Pictured are, from the left: Jonathan Lloyd, Carrickfergus Chemists; Valerie Scott and Glynis Boyd, prescribing advisers to the NHSSB; and Doris Shaw, Calwells Pharmacy, Whitehead

POLICY

Ensure pharmacist presence

Changes brought about by the skill mix proposals must not remove the pharmacist from the pharmacy, PSNC has told the Department of Health.

"We firmly believe that the community pharmacy service can and should be developed to provide easily accessible and convenient care for patients," it says in its response to *Pharmacy workforce in the new NHS*.

"Today the community pharmacist is the only instantly accessible healthcare practitioner. Patients and consumers know they can speak to a pharmacist without an appointment... the gains from removal of this certainty of access must be matched against the losses. Our evaluation is that there are no substantial gains to match against the very substantial losses."

As such, PSNC says that it should continue to be a requirement that a pharmacist is present for dispensing or supply of P and POM medicines.

Arguing that removal of the existing supervision requirement "could remove valuable protection for consumers and prejudice their safety as consumers of medicines", PSNC urges the DoH to undertake thorough research to benchmark present error rates.

Overall, PSNC supports much of the discussion paper, but is disappointed that it includes "little vision of how the skills of the community pharmacist... can be used to address some of the many challenges in delivering improved care that the NHS faces". It also warns against developing services such as medication review in primary care centre settings to the detriment of the already extant community pharmacy arena. "It is indicative only of a lack of commitment to develop use of community pharmacy within primary care, contrary to the assertion in the paper," it says.

It supports the delegation of dispensing tasks to trained staff, but argues that the regulation of senior support staff should include conduct and discipline, alongside training and CPD. "It will not be acceptable for a pharmacist to bear total responsibility for actions taken by a dispenser who has qualifications recognised by the Government as adequate to allow him to dispense without direct supervision; the dispenser must bear the responsibility for his own actions, and the pharmacist for any act or omission of his own."

For more information:

www.psnc.org.uk

MEDICINES

Report on vet POMs due this week

The Competition Commission's report into the supply of veterinary POMs was due to be submitted to the Secretary of State for Trade and Industry on Wednesday as *C&D* went to press.

However, the Department of Trade and Industry was unable to confirm when the report would be made public. The Commission has already provisionally concluded that a complex monopoly exists among veterinary surgeons, wholesalers and manufacturers to the detriment of pharmacists and consumers.

For more information:

www.competition-commission.org.uk

Update 2003

Make your New Year's resolution to do some continuing education a profitable one. By registering for *C&D*'s Pharmacy Update before the end of January you will be in with the chance of winning £2,000.

Every pharmacist who registers for Pharmacy Update before the end of this month will be entered into the Update Knockout Tournament, sponsored by Genus Pharmaceuticals.

Each month, students scoring less than full marks on all accredited articles will be eliminated from the tournament. The last remaining student will win £2,000.

The subscription price remains the same as last year at £25 (£21.28 + VAT) – that's less than £1 for each hour's CE. Pharmacists in Northern Ireland have their fee paid by the NI Centre for Pharmacy Postgraduate Education and Training.

All pharmacists who were registered for Update last year have until February 19 to complete the 2002 MCQs. The telephone marking system for last year's modules will close after that date. Pharmacists will then receive a letter informing them of their final scores.

This week's issue contains the MCQ for the following Pharmacy Update modules carried in December:

- Proton Pump Inhibitors (1255)
- Ear, Nose and Throat (1256)

Pharmacy Update is a distance learning programme accredited by the College of Pharmacy Practice. Previous modules can be accessed on *www.dotpharmacy.com*.

A list of accredited modules for the last three years (2000 - 2002) was printed in last week's *C&D* for reference (*Jan 4, p20*).

The Pharmacy Update multiple choice questionnaire and phone marking service are supported by Genus Pharmaceuticals.

For more information:

www.dotpharmacy.com

E-mail: *mprebble@cmpinformation.com*

Tel: 01732 377269.

Ricin poisoning signs

The deputy chief medical officers in England and Scotland have issued information over concerns relating to a bioterrorism threat of ricin poisoning.

Further to the incident in north London earlier this week, the advice to health professionals is to be alert to the signs and symptoms of ricin poisoning.

Ricin, a protein toxin derived from castor oil seeds, inhibits protein synthesis and has widespread toxic effects on the body. This includes damage to most organ systems.

A combination of pulmonary, liver, renal and immunological failure may lead to death. As no antidote is known, treatment can only be supportive.

The early stages of ricin poisoning are considered difficult to distinguish from those of some infections and may mimic septicaemia. "Diagnosis will depend on a high index of suspicion," the advice says. The effects may be delayed for some hours after exposure, and patients who develop a fever should consult their own doctors.

Early symptoms depend on the route of exposure, but fever, gastrointestinal upset and coughing may be among the first effects noted. Absorption via the lung causes particularly serious lung damage including pulmonary oedema and adult respiratory distress syndrome.

Ricin ingestion irritates the gut, causing gastroenteritis, bloody diarrhoea and vomiting. CNS effects may include seizures and CNS depression.

Detailed advice is available on the Public Health Service Laboratory website and from the National Poisons Information Service or the Scottish Centre for Infection and Environmental Health.

● The flat in which arrests were made last Sunday and in which traces of ricin were found was above the Guardian Pharmacy in Wood Green. A spokesman confirmed on Wednesday that there was no link between the pharmacy business and the flat above, which is believed to be rented to Haringey Council.

For more information:

PHLS: *www.phls.org.uk*
Tel: 0208 200 6868
NPIB: *www.spib.axl.co.uk*
Tel: 0870 600 6266
SCIEH: *www.show.scot.nhs.uk/scieh*
Tel: 0141 300 1100 or 0141 211 3600 out of hours

Pictured at the launch of the automated dispensing system in Llandough Hospital, Wales, are, back row, from the left: Carwen Wynne Howells, Welsh Assembly Government chief pharmaceutical advisor; Clive Jones, Bro Taf HA; Dave Roberts, UHW; Jeremy Savage, chairman, Welsh Pharmaceutical Committee. Front row, from the left: Jane Hutt, health minister; Catherine O'Brien, RPSGB Welsh executive secretary; Andrea Robinson, RPSGB Welsh executive chairman. The Welsh Assembly has allocated £500,000 to install the automated system in two other hospitals in Wales: West Wales General Hospital and Glan Clwyd Hospital

MEDICINES

DTB says Schering should repay NHS

The *Drug and Therapeutics Bulletin* and the Consumers' Association are asking Schering Health Care to repay the NHS £200,000, following the withdrawal of its advertising for Yasmin (*C&D, December 14, 2002, p7*).

The £200,000 sum is the difference in the cost between prescriptions written for Yasmin and the next most expensive contraceptive.

Dr Joe Collier, editor of *DTB*, said: "There must be some recompense for the NHS when doctors prescribe expensive drugs in good faith as a result of misleading promotion claims. Schering should voluntarily repay the excess expenditure without recourse to the law courts."

A spokesman for Schering said the company is "fully behind the product and stands by the claims about its benefits".

For more information:

www.which.net

MEDICINES

Medical advert alert

Health professionals have been warned to be cautious about the claims of adverts in medical journals, even if they appear to include references to "evidence-based" medicine.

Spanish researchers assessed all advertisements for anti-hypertensive and lipid-lowering drugs that had at least one bibliographical reference in six Spanish medical journals in 1997.

The study, published in *The Lancet*, found that in 44 per cent of claims the promotional statement was not supported by the listed reference. Most frequently this was because the advert recommended the drug in a patient group other than that used in the study.

An accompanying editorial by Dr Robert Fletcher, from Harvard Medical School, says readers must take personal responsibility for judging the validity of assertions made in adverts.

For more information:

Lancet 2003, Vol 361: 27-33.

Questiontime

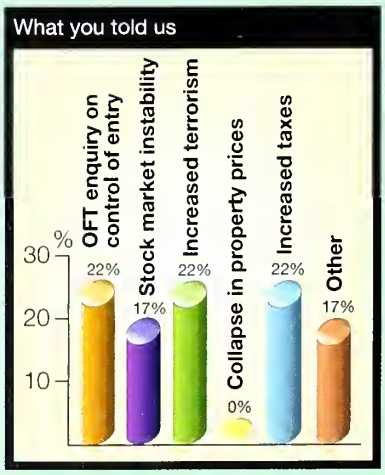
in association with UniChem

Last week we asked you: "Which of the following is your greatest concern for 2003?" You replied (see right):

This week's question: Drug companies have been criticised for 'creating' new medical conditions to boost sales. Which ailment do you think the pharmaceutical industry should target next?

January sales temptation ● Texter's thumb
Back to work blues ● New Year diet hunger pangs
Revenge sullenness

You can record your vote on our website: *www.dotpharmacy.com*. You have until noon on January 14 to cast your vote. We will publish the results in *C&D*, January 18.



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iquid for external use
containing soya oil
84.75% w/w. Uses: For
he treatment of dry
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lermatitis. Dosage
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Adults: For full bath
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neasure. For partial
bath (~5L)-2.5ml=1/8
neasure. For child's
bath (~25L)-5ml=1/4
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be taken weekly. For
babies and infants
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varnings etc: Contra-
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It's important
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Balneum

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E45 Cream is a
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E45 can make eczema management more simple. Not only is E45 the preferred cream for dry skin and eczema among pharmacists and pharmacy assistants,[1] but patients[2] and doctors[3] agree with you too. **It's the No.1 dry skin brand.**

INDUSTRY

Industry accused of 'inventing' new condition

Pharmaceutical manufacturers have been accused of inventing a medical condition (female sexual dysfunction) to create a new market for medicines and increase sales.

A leading article in the *BMJ* (*January 4, p 45*) voices concern that classifying a range of symptoms, including loss of libido and pain during sex, as a dysfunction, which can be caused by emotional stress, tiredness or anxiety, may encourage doctors to prescribe medication when the problem could lie elsewhere.

The article points out that over the past seven years the pharmaceutical industry has funded and attended a series of meetings aimed at drawing up a definition for FSD.

While such a ' medicalisation campaign' could lead to a more humanised doctor/patient relationship and the development of safe and effective new drugs, the article's author, New York journalist Ray Moynihan, also warns of the dangers.

"The potential risk, in a process so heavily sponsored by drug companies, is that the complex social, personal and physical causes of sexual difficulties - and the range of solutions to them - will be swept away in the rush to diagnose, label and prescribe," Mr Moynihan argues.

He says some serious questions are hanging over the often quoted figure of 43 per cent prevalence of sexual dysfunction in females aged between 18 and 59.

The figure is based on a 1992 study which asked 1,500 women whether they had experienced any of seven problems, such as lack of desire and anxiety about sexual performance, during the past year. Answering yes to just one of these meant you were classified as suffering from female sexual dysfunction.

While the phenomenon of 'corporate sponsored creation of a disease' may not be a new one, Mr Moynihan says that "the making of female sexual dysfunction is the freshest and clearest example".

Mr Moynihan suggests the greatest concern is the fact that inflated estimates of disease prevalence and the ever narrowing definition of 'normal' that go with it "help to turn the complaints of the healthy into the conditions of the sick".

A spokesman for the Association of the British Pharmaceutical Industry refuted the suggestions. "It is quite untrue that the pharmaceutical industry invents diseases. It is belittling to what can be a very distressing condition to suggest that it does not exist."

He accepted however that medication may not always be the most appropriate or only option.

SURVEY

Queues and unattractive store design a turn-off

Long queues, an unattractive design and product unavailability are the biggest turn-offs for potential customers, according to a report published by market analysts Mintel.

More than a third of the 1,058 shoppers questioned said they would leave a shop if its design was unattractive, while over half would walk out without a purchase if the queues were too long.

Window displays, though, can have the opposite effect and draw people into a shop, according to 25 per cent of those surveyed.

Last year UK retailers are estimated to have spent as much as £1.6 billion on shop fittings and interiors. The total expenditure on refits and design in 2002 was just under double that amount (£3bn) or 1.3 per cent of total retails sales.

Retail Store Design is available from Mintel, priced at £695.

For more information:

Tel: 0207-6064533.

IT

Ian Shepherd moves into IT consultancy role

The RPSGB' s outgoing head of information systems management, Ian Shepherd, is to move into IT consultancy.

Mr Shepherd will partner a colleague in the running of their business once he retires from his job at the Society at the end of January.

Synapse Consulting will specialise in data quality, cost and project management, mainly in the healthcare sectors, particularly focusing on pharmacy issues.

The company will carry out some project management and technical consultancy for the RPSGB, including the continuance of work towards ensuring that the information contained in the Society's systems, such as the Register, is of the highest quality and integrity.

Synapse will also be assisting the Pharmacy Technology Group (consisting of representatives from the PSNC, RPSGB, NPA, SPCG and Co-op) in their efforts to conduct a comprehensive review of electronic transfer of prescriptions and to produce implementation proposals for adoption by the group and consideration by the Department of Health.

Ian Shepherd: leaving the RPSGB at the end of this month

Some project work for several pharmacy system suppliers is also on the agenda for early in 2003.

Both directors of the company Ian Shepherd and Richard Fisher, are pharmacists with a combined total of 50 years' experience in information and technology in the pharmacy sector.

Mr Fisher said Synapse would welcome involvement in any system that deals with technology and people.

For more information:

E-mail: *info@synapseconsulting.co.uk*

Tel: 01949 860252.

LINKScan system upgraded

AAH Pharmaceuticals has launched an improved version of its hand-held ordering system, LINKScan. Changes designed to make pharmacy ordering with LINKScan faster and easier include:

- a duplicate scanning alert, to inform customers when a product has been ordered more than once
- an improved dial-up system to allow easier transmission of orders
- an order screen to allow pharmacists to send duplicate orders and add additional items to the order more easily
- improved download time for product file updates.

Gordon Davis

Gordon Davis (Chemists) Ltd was incorrectly spelt with an 'e' (*C&D January 4, p10*). The correct spelling is Davis, not Davies.

ComingEvents

JANUARY 13

Nottingham Branch, RPSGB
Atypical Antipsychotics, by Dr David Branford, director of pharmacy, Derbyshire Mental Health Trust, at the School of Pharmacy, Nottingham University, 7.30 for 8pm.

East Kent Branch, RPSGB
CPD Developments, by an RPSGB speaker at the Pilgrims Rest Hotel, Canterbury Road, Ashford, 7.30 for 8pm.

JANUARY 14

Moray & Banff Branch, RPSGB
Curling, at the Laichmoray Hotel, Elgin, 7pm and then the Moray Leisure Centre.

Oxfordshire Branch, RPSGB
Linking Pharmacists with Childrens' Clinics, by Anne Bridgman, primary care paediatric specialist nurse at the George Pickering Postgraduate Medical Centre, John Radcliffe Hospital, 7.30 for 8pm.

JANUARY 16

Wirral Branch, RPSGB
Pharmacist Prescribing, by Clive Jackson, director, National Prescribing Centre, 8pm preceded by AGM 7pm and hot buffet 7.30pm at the Postgraduate Medical Centre, Clatterbridge Hospital.

Illicit prescription payments worth over £48,000 lead to striking off

A disgraced Leeds pharmacist, jailed for cheating the NHS, pocketed at least £48,000 in illicit prescription payments over 16 years, the RPSGB's Statutory Committee was told on December 11, 2002.

Pharmacist Bhupinder Singh Bharj, owner of a pharmacy at 227 Dewsbury Road, Leeds, was found by the NHS's pharmaceutical fraud team to be making inflated claims to the Prescription Pricing Authority.

On June 14, 2002 at Leeds Crown Court, Mr Bharj pleaded guilty to three sample counts of deception and was jailed for six months. He served six weeks and three days. The court sentenced him for defrauding the NHS of £8,894 between October 1998 and September last year, but enquiries have revealed an estimated cost to the taxpayer of a further £39,778 from 1985.

Mr Bharj did not appear before last month's hearing at which the Committee ordered him to be struck him off after finding misconduct, based on the conviction, proved.

Geoffrey Hudson, for the Society, told the hearing that fraud investigators discovered Mr Bharj would typically dispense a quantity of medicine, for example, 500ml, then charge the NHS for five separate quantities of 100ml, which is more expensive.

When questioned, Mr Bharj told inspectors he didn't know he was doing anything wrong, had been taught to bill the NHS this way from his early days in the profession and had been doing so since 1985 before he owned his own pharmacy. "He said he carried out this practice everywhere he worked.

"The pharmacist is currently negotiating compensation with the Prescription Pricing Authority, who will now accept £25,000 rather than insist on the full £39,778, which is a backdated estimate.

"By his own admission he was in breach of trust for many years which renders him additionally to be unfit to remain on the Register," said Mr Hudson.

In Mr Bharj's defence, the Committee heard that: "As soon as he was challenged over the endorsements, Mr Bharj stopped the practice."

Mr Bharj is currently negotiating the sale of his company, Vemtech Ltd, which owns the pharmacy.

"What we have heard is so serious," said Committee chairman Lord Fraser of Carmyllie QC, announcing the Committee's decision to remove Bharj from the Register.

Mr Bharj had a fraud conviction in 1984 and was previously struck off in September 1994 for selling outdated, returned and substituted medicines, often by unqualified staff.

He has three months to appeal against the decision.

Four times too many angina tablets prescribed

A man had to be hospitalised after a pharmacist dispensed a prescription instructing him to take four times the maximum dose of angina tablets, the Statutory Committee heard on December 12, 2002.

The sick man's wife, named only as "Mrs B", had gone into the E Moss Ltd pharmacy on King Street, in Cottingham, Hull, on August 28, 2001 with a prescription for 224 bisoprolol tablets 10mg, at a dose of eight tablets daily - the usual dose is 5-10mg daily with a maximum of 20mg.

Pharmacist Elaine Hutton of Cottingham gave Mrs B five boxes of the medication labelled "take eight daily", claiming she "knew strange doses were used in hospital".

But within half an hour of taking his first dose of eight tablets, Mr B had to be rushed to Hull Royal Infirmary where he was admitted for six days for an overdose, the Committee was told.

"The woman was advised she would have to return to get the remaining three boxes that were still due to her. No other advice or instructions were given," said Committee chairman, Lord Fraser of Carmyllie QC.

"In spite of the serious nature of this we're glad to hear Mr B recovered.

"Ms Hutton explained she assumed the prescription had initially been written by the hospital consultant before being written by a GP. She said she knew strange doses were used in hospital."

Lord Fraser was "concerned about the lack of symmetry between the dispenser and the prescriber" after Ms Hutton said she had been warned off by a GP at the South Street surgery in Cottingham after she had been found handing out leaflets warning her customers at the pharmacy that a brand of HRT was made involving animal cruelty.

Lord Fraser added that although it was "incumbent on Ms Hutton to query the strange dose, if she had made contact and had been told, as she feared, to mind her own business, it is not clear to me what would have happened next. However, as she did not call we need not explore the case."

The Committee decided that it was a "single dispensing error" but restricted itself to a reprimand.

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CROOKES HEALTHCARE

Comment from the Editor

Two more key responses to the skill mix proposals have been published (*see p6, 7*), suggesting the Government has some serious thinking to do.

Surprisingly, it is the RPSGB which has raised the issue of finances, telling the Department of Health to incorporate community pharmacy more fully into NHS training and development plans. The Society has often shied away from mentioning money, but this time it has told the DoH that any changes which may result, for example to supervision requirements, will need adequate resourcing.

From the main negotiator, PSNC, the tack is somewhat less finance-focused. Instead, it supports the NPA view that the pharmacist's natural home is the pharmacy. To allow pharmacists time out to visit patients or surgeries to the detriment of medicines supply or the giving of advice will damage the public's confidence in the community pharmacist as the only NHS health professional who can currently be seen without an appointment.

While the Society raises the prospect of pharmacists leaving the premises, it too does not endorse this view, worrying about the potential loss of access to pharmaceutical care.

However, the apparent government desire to see the regulation of everyone providing healthcare services to the public opens up the question of whether dispensers in GP surgeries or attendants in garages selling GSL medicines will need to be regulated. And as regulation is unfeasible for the latter group, the Government should look again at its P to GSL policy. The RPSGB argued this point well. It's a refreshing change to see Lambeth becoming a political animal. More please.

One other thought is that as pharmacy staff progress in experience and responsibility, they will expect an increase in the money they are paid. How affordable will those staff be if pharmacy remuneration models are unable to take this aspect of cost into consideration? The Treasury will balk at funding training, but to then have to increase the professional fee...

The Government should look again at its P to GSL policy

PAGBperspective

How will our records be judged?

Will CPD checks be made relevant to you? asks Sheila Kelly, executive director of PAGB

Feeling a bit guilty about neglecting my pharmacy training recently, I made time to watch the Society's video explaining about mandatory continuing professional development.

I was left wondering what all the fuss is about, especially since a straw poll among my friends revealed that architects, solicitors, doctors and teachers have long been required to do CPD to practise. I decided to download the information pack from the RPSGB website to learn more.

You don't have to be a pharmacist to be executive director of PAGB and it is over 20 years since I did any dispensing but I do keep up to date with the changes within the profession. My work on POM to P and my current representational and regulatory work involves knowing about ingredient safety and efficacy, communication and medicines controls. I wouldn't think of taking on a dispensing role without a refresher course, but I should be able to record around one CPD activity a month as the information pack suggests. I am sure this must be true of all practising pharmacists. So why was I left feeling uneasy about CPD?

I have worked in industry for most of my career. We have personal development records, which are very similar to the CPD template, which set personal objectives for staff. However, we develop them in discussions between employers and employees and they relate directly to the job or a job in the future.

If someone is going to judge whether I am competent to be a pharmacist I expect to be able to discuss and consent to the standards by which I am judged. So I am pleased that in order to file and audit the records the Society is

setting up new electronic links created for CPD to communicate directly with us. I will expect to get information and feedback directly through that link so everyone will be involved in the changes.

However, my major concern is that the CPD information pack says that the records will be checked and audited but doesn't say what criteria will be applied in reviewing the records. These criteria may eventually help define who can be a registered pharmacist when the requirement becomes mandatory so it's no small omission, especially when there is no clue yet to the process by which they will be developed. The fact sheets suggest that the outcome could be a pharmacy register divided into active and inactive sections and I don't like the sound of that.

So my personal New Year resolution is to get started on my records and get involved in the CPD debate, so down the line I can continue to describe myself as a pharmacist. Or I might just keep an eye out for what might be the safest pharmacy jobs of the future – a post as one of the reviewers who will be checking the CPD records!

Northern Ireland NOTEBOOK

Training has missed the point

"During the second of the three evenings I began to lose the will to live... the content was excruciatingly boring and the level of intellectual challenge was pitched at simpletons."

This crushing comment came from a colleague after a recent NICPPET course on "prescribing support". What is going on? A letter from NICPPET in October suggested that only those completing this course would benefit from funding for antibiotic audits in GP surgeries.

A number of colleagues expressed concern at the time required to undertake this detailed training programme for a role that we should be able to do anyway.

Personally I am happy with the principle that training would normally be required for any new service and this should not have been an exception. However, now that I know more about the course I am concerned.

For some years now NICPPET has been supporting CPD for pharmacists

For some years now NICPPET has been supporting CPD for pharmacists. Both it and the PSNI are telling us that the first step in CPD is to identify training needs. If this applies to pharmacists, it must also apply to the trainers.

From anecdotal feedback those wishing to help with audits in GP surgeries got little help from the course. By simply picking an NICPPET course and making it mandatory for those wishing to take on a new service, whether or not the course improves competency, seems pointless.

Normally I am impressed with all the NICPPET does and hope it will take this comment in the constructive way it is intended.

Written by a Northern Ireland community pharmacist

TOPICAL REFLECTIONS

At the risk of repeating myself...

If the media reports of an official opinion survey are to be believed, disillusionment among GPs is on the increase. The National Primary Care Research and Development Centres at Manchester and York Universities, reported in *The Lancet*, found that of those GPs surveyed, 20 per cent would like to quit the NHS within the next five years.

If a similar survey were conducted among community pharmacists I would predict an even worse level of dissatisfaction, but when I look at my current work I cannot honestly say that I dislike what I am doing. On the contrary, I enjoy the pharmacist-patient contact. However, I do suffer a high degree of frustration at the lack of progress towards achieving increased responsibility.

I then read that John Chisholm, chairman of the BMA's General Practitioners' Committee, says that GPs would like to ease pressures on their time by transferring some of their work to pharmacists.

So in a nutshell GPs are complaining of too much responsibility, while pharmacists are complaining of too little! A slightly simplistic viewpoint but fundamentally true. I could help reduce the workload of GPs by taking responsibility for repeat prescribing and, coincidentally, satisfy the most common complaint registered by my patients.

In this one area the Department of Health should be listening to patients and urgently pursuing the goal of transferring all repeat prescribing to pharmacists. It will require access to patient records, the updating of most computer systems, the training of support staff, dramatic changes to our contract, the establishment of proper consultation facilities and patient registration.

An enormous task, but one that would do more to revolutionise pharmacy practice, release GP time and improve the health of the population than almost any other change in primary care.

Dispersible aspirin doesn't live up to its name

I have known for a long time that dispersible aspirin tablets 75mg vary in the time taken to disperse in water. I try to warn patients of this problem but some still do return to complain.

The other day an elderly gentleman returned with the same old complaint but this time my normal pantomime of demonstration produced an unexpected result. Ten minutes of hard work only resulted in a flocculated poor dispersion of aspirin at the bottom of the measure. I hastily accepted his complaint and changed the offending tablets but the story does raise the question of standards.

In an industry famed for its innovative formulatory skills why can't a simple preparation like dispersible aspirin be produced to a standard that does not drive both patient and pharmacist to distraction?

The borrowing habit is getting critical

Over the holiday period I have been asked to loan drugs to patients far more then ever before. It now seems accepted practice that when a patient runs out of prescribed medication they borrow a few days supply rather than try to persuade the surgery dragon that continuity of treatment really is the responsibility of the doctor and not the pharmacist.

I know I am not alone with this problem but it has reached serious proportions when a patient threatens me with taking his custom elsewhere unless I comply with his request! In this case I stood my ground and watched another small portion of my pay packet angrily disappear out of the door, but at the end of the day the supply of Prescription Only Medicines without the authority of a valid prescription is an offence.

To compound the problem, most modern pharmacy software packages contain loan facilities with reconciliation written into the programmes. These would not be there unless pharmacists had requested them!

In the interests of competition many pharmacists are at the very least bending the law while their more conscientious colleagues not only have to cope with more angry patients but also lose custom. Over to you, Mr Inspector!

Yourviews

Ple@se e-mail your views to chemdrug@cmpinformation.com

Generics (UK) and Discovery

Following the recent article, *Voyage of Discovery (C&D November 9, p37)* Generics (UK) would like to clarify its position with regards to Discovery Pharmaceuticals going forward, and state that we have no intention of supplying Discovery with any products in the future.

Furthermore, we fully support the recent view expressed by John Beighton, chairman of the British Generic Manufacturers Association *(Your Views C&D December 14, p15)* and will continue to support the Government and pharmacists by providing low cost, high quality generic medicines.

Luke Hart
Head of marketing, Generics (UK) Ltd

The perils of changing pack sizes

I would like to draw the attention of fellow pharmacists to the following problem.

Ensure Plus liquid food supplement has changed pack size from 200 to 220mls. I am still being offered 200ml packs by wholesalers and also some 200ml PI stock with a small price advantage.

I considered that when dispensing the 200ml pack I should just dispense 10 per cent more of the 200ml pack to equate to the 220ml ordered.

My local pricing office has a different view on this and advises that I will only be reimbursed at the lowest full pack equivalent, which for a 10 per cent size difference will be multiples of 11 x 200mls – equivalent to 10 x 220mls.

If I dispense any amount in between I will be severely disadvantaged financially. The offer of a cheaper PI product in a different pack size may appear appealing at first sight, but beware of the hidden dangers that can hit your pocket.

S Smith
Nelson, Lancs

Dr Gordon Geddes, PSNC, says:

"The change of pack size as illustrated by Ensure Plus from 200 to 220ml is an unwelcome irritation.

"Since the product in question is treated as a special container of 220ml, community pharmacists are obliged to dispense the number of special containers nearest to the quantity ordered, rounding down if half way. Unfortunately neither the 'PC'(prescriber contacted) nor the 'PNC' (prescriber not contacted) conventions cover a change of quantity.

"However, I can see three possible approaches to easing the problems outlined by Mr Smith. The provider of a database for the majority of prescribing systems will be contacted to ensure (no pun intended!) that the appropriate pack size is held.

"PSNC will discuss with the DoH a possible extension to the "PA" (prescriber approved) facility which allows for changes of quantity with the approval of the prescriber.

"As a longer term solution, PSNC will investigate the possibility of an order for one quantity to be authorised for the pharmacist to prescribe a different quantity as a supplementary prescriber."

Find out more about Galen Lodge

May I bring to your readers' attention through the columns of *C&D* the availability of a website which gives information on the Galen Lodge, a masonic lodge which was founded by members of the pharmaceutical and closely related professions and whose founders and early Masters included a number of noteworthy members of the Pharmaceutical Society.

The internet address of the site is: *http://www.galenlodge.co.uk.*

On this site there is considerable information concerning the Galen Lodge and, should a reader be interested, an e-mail link for contact with the Lodge.

Dr LK Fowler

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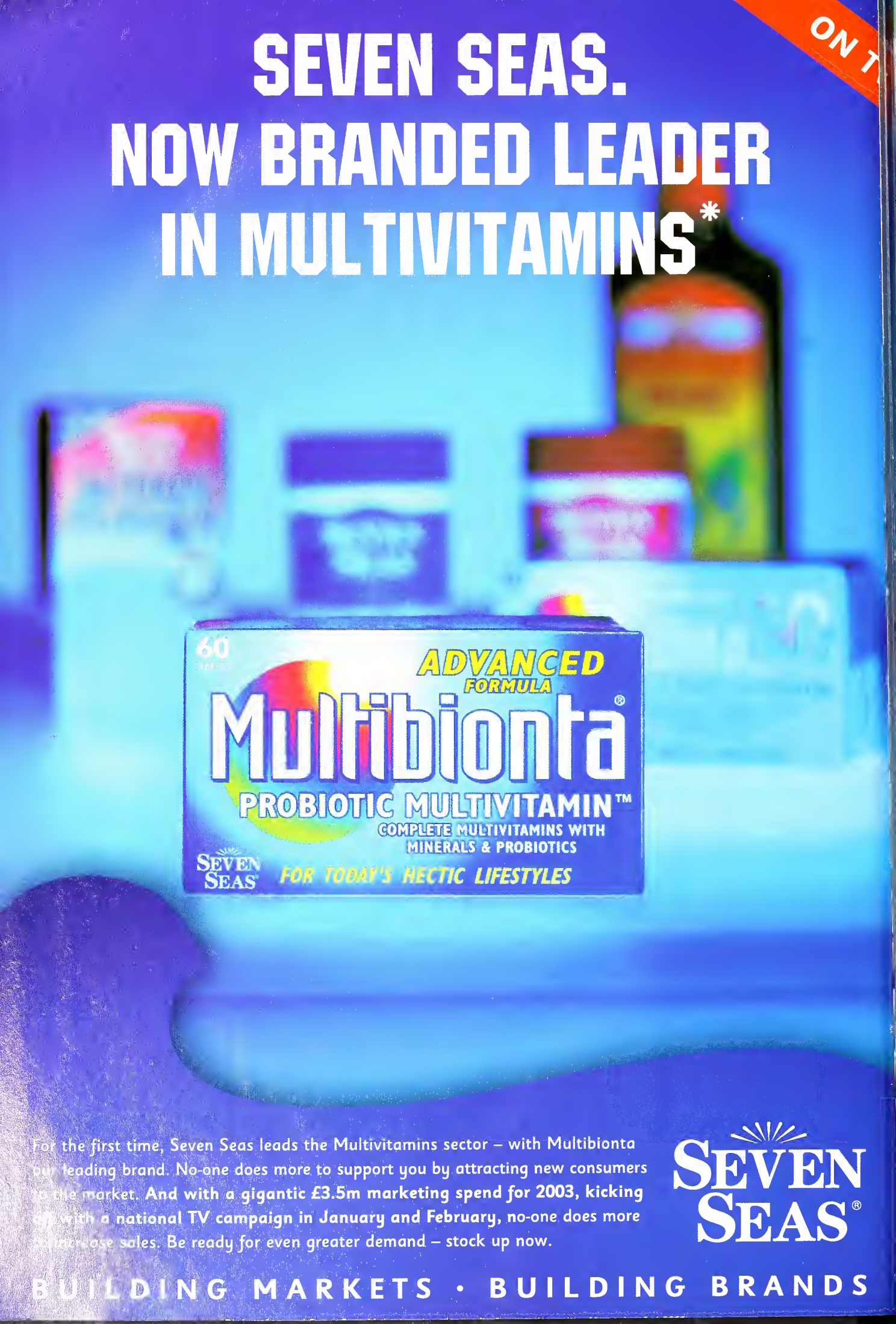

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Most drugs have the potential to cause gastrointestinal symptoms. In the first of two articles, *Derek Balon* looks at drugs that can adversely affect the upper GI tract

Is it the drugs?

THE COLLEGE OF PHARMACY PRACTICE

This course (module 1257), in association with multiple choice questions being published in C&D February 1, provides one hour's continuing education

Objectives

- To be aware of the drugs that can cause upper GI symptoms
- To understand why these adverse effects occur
- To appreciate the degree of risk they present
- To review the symptoms of GI drug problems
- To understand the mechanism of side effects

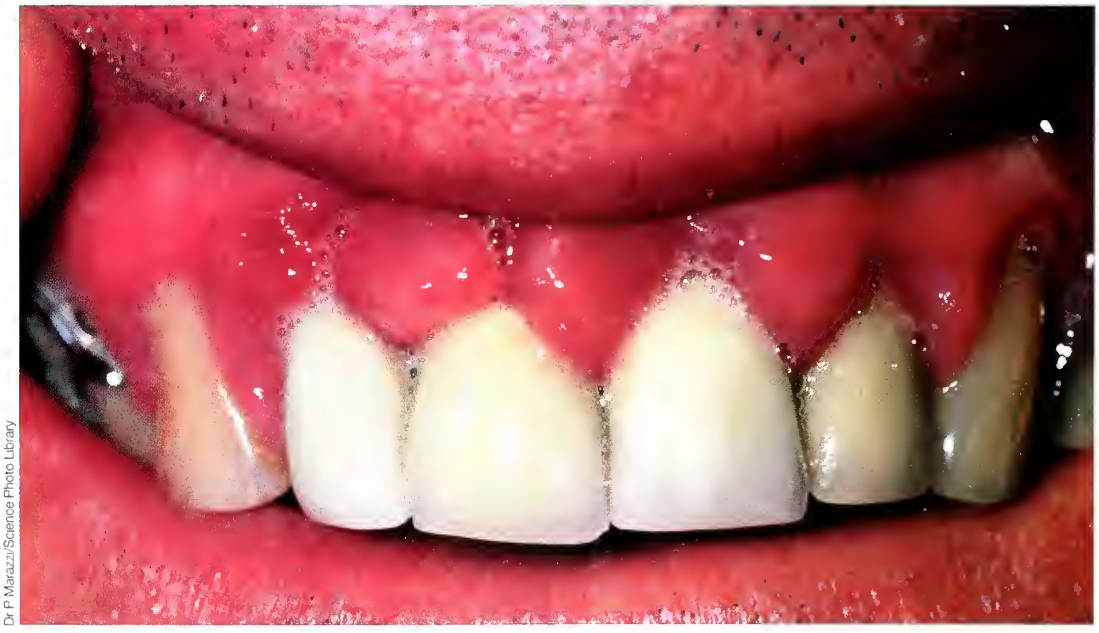
Even a casual look through the side effects of drugs reported in the *BNF* shows that almost all oral preparations are the potential cause of some form of gastrointestinal disturbance. While many are mild and transient, there are a considerable number that should be considered as long lasting and severe.

These complications often involve damage to the lining of the gastrointestinal tract, which, if untreated or unrecognised, may have implications for wellbeing, health and nutrition.

In the UK about 580 million prescriptions are dispensed each year in the NHS. There are also about 600m packs of OTC medicines for internal use sold in the UK.[1] One study reported that between 20 and 40 per cent of gastric disorders were due to an adverse drug reaction.

This suggests that there is a considerable problem associated with taking drugs orally and, although many of these problems may be minor, the number involved is vast. So even if only a small percentage are serious, the number of people who may suffer is considerable.

Common adverse gastrointestinal effects include diarrhoea, constipation, nausea, vomiting, stomach pain, gastric haemorrhage, colonic pain, spasms, indigestion and gastric reflux. Less common are mouth ulcers, taste disturbance, dry mouth, gum problems, malabsorption and colitis. Some of these symptoms have an identifiable lesion but most are visibly silent. Usually, the effects are transient and cease when the drug is discontinued but unfortunately some leave serious and more long lasting sequelae.



Dr P. Marazzi/Science Photo Library

Gingival enlargement caused by calcium channel blockers

The mouth

Drug-induced oral lesions

Aspirin has a deleterious effect by direct action on the mucous membrane. Problems can result from placing an aspirin tablet directly on a painful tooth: a treatment to be discouraged.

Mouth ulcers may result from cytotoxic drugs, NSAIDs, gold compounds, sulfasalazine and proguanil. The adverse effects of the sulfonamides (including trimethoprim rarely), penicillins, NSAIDs and carbamazepine may include a more serious form of ulceration – erythema multiforme (of which Stevens-Johnson syndrome is a form). This is a skin condition that may involve all the intestinal tract and the mouth.

Stomatitis

Any allergen may produce contact stomatitis if repeatedly used. Substances responsible may include mouthwashes and toothpaste, throat lozenges and pastilles, and chewing gum.

Xerostomia (dry mouth)

Dry mouth is the result of decreased saliva secretion. Some of the drugs implicated are shown in *Box 1*. Xerostomia may cause dietary problems as it may alter a patient's ability to taste, swallow and chew. A secondary effect is atrophy of the oral mucosa, which may lead to fissures, inflammation, a sore tongue and gingivitis.

Taste: drug-induced taste disturbances rarely involve total loss, only reduction (hypogeusia) or distortion (dysgeusia) of the taste sensation. Such disturbances are usually reversible but it may take some months after drug cessation. These taste changes may affect drug compliance and appetite, which may lead to poor nutrition.

Gingival enlargement

Drugs with the potential to induce gingival enlargement are shown in *Box 3*. Symptoms are an overgrowth of the gingiva accompanied by pain and bleeding. In severe cases the gingiva may cover nearly all the teeth. Good oral hygiene appears to lessen the incidence. While many cases resolve on drug cessation, this may not be possible

Continued on page 20

Box 1: Some drugs that may cause xerostomia (usually reversible)

- Anticholingerics
- Antispasmodics
- Anti-arrhythmics
- Antihistamines (first generation)
- Anticholesterol agents
- NSAIDs
- H2 antagonists
- Proton pump inhibitors
- Tricyclic antidepressants
- Anti-Parkinson drugs

Box 2: Drugs that may cause taste changes

- Penicillamine
- Captopril and some other ACE inhibitors
- Imidazoles
- Gold compounds
- Metronidazole
- Acetazolamide
- Quinolone antibiotics
- Carbimazole
- Benzodiazepines
- Lithium

Box 3: Some drugs with the potential to cause gingival overgrowth

- Phenytoin
- Cyclosporin
- Calcium channel blockers

as the offending drug may be essential. In these cases surgical removal is required but regrowth is possible unless the causative drug is discontinued.

The oesophagus

Damage to the oesophagus is rare but should always be considered. When swallowed, non-chewable tablets and capsules usually pass rapidly from the mouth to the stomach. Rarely they get lodged in the oesophagus, dissolving or disintegrating locally on the oesophageal wall. This is especially true of gelatine capsules. Any drug may cause local irritation, either because of the local high concentration or its direct adverse effects. Some drugs reduce motility or, if the mucosa is damaged, lead to secondary infection.

The symptoms of such damage include dysphagia (difficulty in swallowing), odynophagia (pain on swallowing), heartburn and a dull ache in the chest or shoulder. The severity ranges from minor to severe. In most cases acute damage resolves within 10 days of stopping the drug.

Oesophageal ulceration has been reported with tetracycline, doxycycline (especially capsules), aspirin, ascorbic acid, the bisphosphonates and potassium chloride. Patients should take the preparation standing up, with a reasonable quantity of water *(see part 2, C&D January 18)*. Note the *BNF* precautions on food avoidance for bisphosphonates.

Gastro-oesophageal reflux disease (GORD)

Heartburn or GORD (known as GERD in the USA) is the result of exposure of the oesophageal mucosa to the low pH content of the stomach. This may have many causes including direct drug action on the lower oesophageal sphincter, hiatus hernia (which may cause sphincter incompetence), impaired motility of the oesophagus, poor mucosa due to injury, increased gastric secretion, stomach overload and delayed gastric emptying time. Some of these organic factors are themselves the result of the side action of a drug.

Normally the pressure of the lower oesophageal sphincter prevents passage of the stomach content into the oesophagus but some drugs reduce this pressure. Some examples of drugs that may cause oesophageal problems are shown in *Box 4*. Those lowering sphincter pressure are indicated with an asterisk.

The stomach

Nausea and vomiting

Many drugs listed in the *BNF* may induce nausea and result in vomiting *(Box 5)*. Some invariably produce these effects, some only cause them rarely and in some the effects resolve on continued use. In some cases these symptoms are a warning of drug toxicity and require discontinuation of the drug (digoxin, theophylline).

The vomiting centre and the chemoreceptor trigger zone in the brain play an important part in the side actions of drugs to produce nausea and vomiting. While the exact mechanism of this action is not known, serotonin is probably one of the neurotransmitters involved. Although the above brain regions are often involved in these symptoms, some drugs produce a direct irritant action on the gastric mucosa (for example, potassium and iron salts), which may evoke the same response.

All drugs have a specific emetogenic potential so that, if the dose is high enough, nausea and vomiting are usual. For example, different cytotoxic agents have differing potentials; cisplatin has a high potential, vinbastine medium and vincristine low. Chemotherapy-induced vomiting appears to be more common in females and the young. Radiology, used in the treatment of cell proliferation, may cause nausea and vomiting.

The nausea/vomiting side effect is often dose-related, but many patients develop tolerance to many of the offending drugs: continued use produces fewer or eventually no effects.

Gastro-mucosal injury (haemorrhage and ulceration)

Apart from the NSAIDs and drugs specifically discussed below, the list of drugs that may cause gastrointestinal symptoms is too long to publish here. Meyler's *Side Effects of Drugs*[2] reports over 120 including acetazolamide, buspirone, the fibrates, griseofulvin, ketoprofen, ramipril, selective serotonin reuptake inhibitors, sulfonamides, mesalazine and zopiclone.

The NSAIDs (including aspirin) constitute the major threat to patients. In the UK more than 22 million NSAID prescriptions per year are dispensed. Of the 228 million packs[3] of oral analgesics sold each year the majority will be NSAIDs, although paracetamol will contribute significantly to this figure. Thus even if only a small percentage of patients taking these drugs suffer an adverse reaction, the number of patients at risk is enormous. It should be noted that while NSAIDs are an important cause of iatrogenic disease, this is due less to their intrinsic toxicity and more to their widespread use.

The mechanism by which gastric damage results from any drug is complex. It is suggested that the NSAIDs have a duel damage pathway:

- suppression of prostaglandin production
- direct acid mediated damage on the mucosa.

Prostaglandins help maintain the integrity of the gastric mucosa

Continued on page 22 ▶

Make sure they're covered in the morning

When smokers are trying to quit, mornings can catch them unawares. Once they've been without nicotine for 6-8 hours, cravings can be intense and hard to resist, which is why many smokers get more cravings in the morning than the rest of the day. Indeed, two out of three smokers light up within 30 minutes of waking.

NiQuitin CQ patches provide nicotine continuously over a 24-hour period, reducing morning cravings compared with a 16-hour patch, for these heavily dependent smokers.[1]

Don't let increased morning cravings increase their risk of relapse. Recommend *NiQuitin CQ* 24-hour patch and help smokers quit from the word go.

Nicotine

The confidence of 24 hour protection

Box 4: Some drugs that may cause oesophageal problems

- Alendronate
- Tetracycyline
- Doxycycline
- Aspirin
- NSAIDs
- Potassium chloride
- Capsules
- Ascorbic acid
- Calcium channel blockers*
- Alcohol*
- Nitrates*
- Antimuscarinics*
- Tricyclic antidepressants*
- Theophylline*
- Drugs that reduce sphincter pressure.

Box 5: Some drugs that may cause nausea/vomiting

- Cytotoxics
- Ergot alkaloids
- Colchicine (often preceded by diarrhoea)
- Levodopa
- Opioids
- Selective serotonin reuptake inhibitors (>20 per cent)
- Systemic vasodilators
- Theophylline
- Digoxin (toxic level)
- Iron salts
- Potassium salts

Delayed gastric emptying

This condition rarely presents a serious medical problem but produces unpleasant symptoms including:

- Nausea (see above)
- Stomach pain
- Vomiting some hours after food ingestion
- A feeling of "bloating" and "fullness"
- Heartburn (see above) and food regurgitation

Antimuscarinics, opioids and some anti-Parkinsons' drugs may cause delayed gastric emptying. A non-drug cause is clinical depression

by controlling its secretion of both mucous and biearbonate. They also maintain mucosal blood flow, another important factor in gastric damage. Thus reduction of these compounds may lead to mucosal damage.

It should be noted that as these effects are systemic they are not just related to local activity on the intestinal lining, so NSAIDs administered other than the oral route may still cause damage. This systemic activity accounts for the less than anticipated advantage of enteric coated and rectal preparations.

The inhibition of prostaglandin biosynthesis is thought to result from inhibition of cyclo-oxygenase activity. The discovery of two cyclo-oxygenase enzymes COX-1 and COX-2, with different sites of action, suggested it might be possible to develop targeted NSAIDs that primarily inhibited one or other of the COX enzyme systems.

COX-1 is involved in production of the prostaglandins responsible for gastric protection, while COX-2 is involved in production of the substances (possibly including prostaglandins) causing inflammation. COX-2 appears to be induced by the inflammatory processes, its concentration increasing with time at the site of the damage.

COX-1 enzyme is specifically expressed by stomach tissue so COX-1 inhibitors are more likely to result in stomach damage. Drugs inhibiting COX-2 are theoretically less likely to have this effect. The present situation is that the newer COX-2 inhibitors have been shown to cause gastric damage but to a lesser degree than COX-1 inhibitors. It may well be that future development produces more selective drugs. One effect of NSAIDs is direct irritation at the local site, weakening the resistance to acid. This may result in gastritis, ulcers, bleeding and perforation. Symptoms include dyspepsia (indigestion), gastric pain, diarrhoea, nausea, vomiting and blood in stool (either visible or occult).

Different NSAIDs have differing propensities to produce these symptoms *(Box 6)*. The *BNF* states that "... differences in anti-inflammatory activity between different NSAIDs are small..." so that "...the prescriber should weigh efficiency against possible side effects".

Ulceration

The two major drugs to produce overt ulcers are potassium and the NSAIDs. Risk factors include: age over 60 years, a previous history of ulceration, concomitant corticosteroid therapy and high NSAIDs dosage. Ulcers may produce typical symptoms of pain (overt) or there may be no symptoms (silent – only diagnosed by specific examination). Drug-induced ulceration is mostly in the stomach (note exception below).

Potassium produces direct epithelial damage; its ionic effect causes local vasoconstriction and results in mucosal ischaemia. Enteric coated tablets, while reducing these effects in the stomach, may result in small intestinal damage.

There is some evidence that systemic corticosteroids may increase the risk of peptic ulceration and the risk of haemorrhage appears to be increased (about 50 per cent).

Anticoagulants may cause gastrointestinal bleeding: the higher the INR the greater the risk. Symptoms include haematemesis and blood in stool (both overt and occult), melaena (black, tarry stool) and anaemia. It should be remembered that one of the effects of gastric ulceration is haemorrhage.

Box 6: The relative risk of gastric effects of some NSAIDs

High
- Azapropazone

Medium
- Piroxicam
- Indometacin
- Naproxen
- Diclofenac (some authorities place this in the low risk group)
- Aspirin

Low
- Ibuprofen

References:
1. and 3. Extrapolated from figures provided by the Proprietary Association of Great Britain (with thanks).
2. 2000, Meyler's Side Effects of Drugs 14th Ed. Elsevier Science BV, Duke MNG and Aronson JK (ed), Amsterdam.

Derek Balon is a community pharmacist and visiting lecturer at King's College, London.

Actionplan

1. In your practice workbook note any comments by patients reporting any adverse drug reactions (that is, actual or suspected, and not just Yellow Card incidents but any effect, including upset stomach etc). Note the offending drug, the symptoms and how the problem was handled.
2. After you have, say, 50 responses, analyse the results and compare how many are GI related. Compare the number of your reports with the approximate number of prescriptions you dispensed over this potentially long period. Does the ratio bear any relationship to the incidence of adverse drug reactions reported in the literature?
3. Is any class of drug particularly implicated?

Distance learning for pharmacists

Pharmacists using **Pharmacy Update** for continuing education are reminded of the need to test. With the support of Genus Pharmaceuticals, C&D's readers can self-test their progress by using the multiple choice question (MCQ) paper to be inserted in the February 1 issue, which will cover this week's CPP-accredited articles, together with those in the January 18 and 25 issues.

These will cover:

GI side effects part 1 (1257) ● GI side effects part 2 (1258) ● Endocrine system (1259).

The distance marking service offers independent verification of results – details on the monthly MCQ papers. Readers wanting to register for Pharmacy Update can contact Mary Prebble on 01732 377269.

in association with

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Our reps often go the extra mile. On one occasion, a pharmacist in York was having staffing problems and struggling to find someone to deliver oxygen to a patient. Our rep, Stuart Marrett, not only delivered the oxygen in person but also returned the used cylinder to the pharmacy. So it's not just our award-winning inhalers that help patients breathe more easily.

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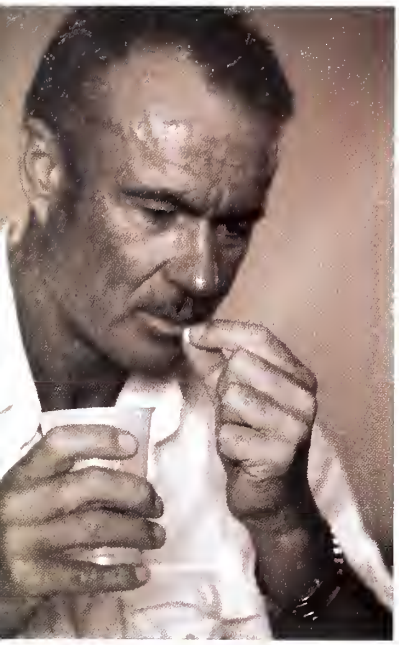


Wider metformin use recommended

Metformin should be used to treat type 2 diabetes more widely, as it is the only oral hypoglycaemic agent proven to reduce cardiovascular mortality, according to an editorial in the *BMJ*.

The UK prospective study on type 2 diabetes showed that using metformin in obese patients reduced cardiovascular events and it is the only hypoglycaemic agent shown to reduce the macrovascular complications of diabetes.

However, guidelines about the use of metformin and the risk of lactic acidosis may limit its use and cause confusion among doctors. The editorial says that lactic acidosis is rare (one to five cases per 100,000) and there is little evidence for lactic acidosis secondary to the accumulation of metformin as it is excreted solely through the kidney, has a short half-life and does not affect lactate concentrations in diabetic patients. Mortality from lactic acidosis is predicted by the severity of underlying tissue hypoxia and so metformin should be withdrawn in patients with tissue hypoxia.

The editorial also queries the advice given in the *BNF*. This says: "Metformin should also be avoided (or discontinued) in other situations which might predispose to lactic acidosis." The authors ask that as diabetes predisposes people to the accumulation of lactate should metformin not be used in the treatment of diabetes? It also criticises the use of "vague and unhelpful" terms such as renal or hepatic impairment.

The authors call for a simplified and pragmatic set of guidelines to be adopted which stress the importance of renal clearance of metformin and withdrawal of the drug in patients with tissue hypoxia.

For more information:

BMJ 2003, Vol 326; 4-5.
www.bmj.com

Scriptlines

Keep Nyogel upside down

Novartis has revised the storage requirements for Nyogel (timolol 0.1 per cent) eye gel.

Once opened, the dropper bottle should be stored upside down in the carton below 25°C, says the company.

For more information:

Novartis
Tel: 01276 692255.

Update on Nivaquine

The special warnings, interactions and undesirable effects sections of Nivaquine's (chloroquine) SmPC have been updated.

Under precautions for use, it now states that Nivaquine should be used with care in patients with psoriasis as the condition may be exacerbated.

Nivaquine should also be administered at least two hours apart from antacids or kaolin to ensure absorption is not reduced. Cimetidine may decrease clearance of Nivaquine, and co-administration with mefloquine may increase the risk of convulsions.

Also concomitant administration of Nivaquine and digoxin may increase plasma concentrations of digoxin.

In addition, Nivaquine's side effects are now classified into 11 different sections for clarity.

For more information:

Sanofi Pharma
Tel: 01732 534000.

Angiotensin-II receptor antagonists for migraine

A small study has shown that angiotensin-II receptor antagonists may provide effective prophylaxis for migraine headaches.

As reported in the *Journal of the American Medical Association*, 60 migraine sufferers aged 18-65 years were randomised to receive candesartan cilexitil 16mg once daily or placebo in a double-blind, placebo-controlled crossover study.

Following a placebo run-in period, two 12-week treatment periods were separated by four weeks of placebo "washout". Thirty patients received candesartan in the first treatment period and placebo in the second and the other 30 *vice versa*.

In one treatment period of 12 weeks the mean number of days with headache was 18.5 in the placebo group and 13.6 in the candesartan group. The treatment group also showed advantages in the secondary end-points of hours with headache, days with migraine, headache severity index and level of disability. The tolerability profile of candesartan was similar to that of placebo.

The UK Medicines Information Pharmacists Group has produced a summary of angiotensin-II receptor antagonists (A2RAs).

The main points are:

- all A2RAs are licensed for the treatment of hypertension and demonstrate similar efficacy in lowering blood pressure at licensed doses; losartan is the only one with evidence of benefits in terms of morbidity and mortality relating to hypertension
- telmisartan is currently the cheapest A2RA when used in standard antihypertensive doses
- irbesartan is licensed for the treatment of renal disease in patients with hypertension and type 2 diabetes as part of an antihypertensive drug regimen
- none of the A2RAs are licensed for heart failure and there is no published evidence to show that they reduce mortality when used for this indication
- A2RAs are not generally considered a first-line treatment but provide a therapeutic option in those patients intolerant of an ACE inhibitor.

For more information:

JAMA 2003; 289: 65-69
http://jama.ama-assn.org
www.ukmi.nhs.uk

Celecoxib vs diclofenac and PPI

Among arthritic patients with a recent history of ulcer bleeding, treatment with celecoxib was as effective as treatment with diclofenac plus omeprazole in the prevention of recurrent bleeding, says a study in the *New England Journal of Medicine*.

In the intention-to-treat analysis 287 patients whose previous ulcers had healed, and were negative for *Helicobacter pylori*, received either celecoxib 200mg twice daily plus placebo or diclofenac 75mg twice daily with 20mg omeprazole daily for six months.

Recurrent ulcer bleeding occurred in seven patients receiving celecoxib and nine receiving diclofenac/omeprazole. The probability of recurrent bleeding during the six-month period was 4.9 per cent for patients who received celecoxib and 6.4 per cent for patients who received diclofenac plus omeprazole.

Renal adverse events including hypertension, peripheral oedema and renal failure occurred in 24.3 per cent of celecoxib patients and 30.8 per cent of diclofenac patients. The authors suggest further studies of a COX-2 NSAID in combination with a proton pump inhibitor or misoprostol will eliminate the risk of ulcer complications for patients with multiple risk factors.

For more information:

NEJM 2002, Vol 347, No 26: 2104-2110.
www.nejm.com

Zirtek Allergy thinks big in pharmacy

Following the recent reclassification of cetirizine from POM to P status for all pack sizes above seven tablets, UCB Pharma's stock of new Zirtek Allergy 30 tablet Pharmacy packs is now available.

This pack replaces the existing 30 tablet POM pack and can be used to fulfil FP10 prescriptions for Zirtek 10mg and cetirizine tablets 10mg.

The pack is suitable for chronic or year round allergy sufferers, when more than one member of the family suffers. The tablets can be recommended for adults and children six years and above.

From March,new point of sale material will highlight the message that Zirtek Allergy is now available in packs of 7,14 and 30 tablets.

Price: £14.95

Pack size: 30 tablets
Pip code: 044-7771
Laser Healthcare
Tel: 01202 449700.

Why seeing is believing

Vitabiotics is relaunching its Visionace eyecare supplement in February with an improved one-a-day formulation.

Visionace vegetarian tablets will be reformulated with 23 nutrients to maintain eye health.

The ingredients include balanced levels of antioxidant vitamins, bilberry extract, natural carotenoids and minerals such as selenium and zinc.

The formulation also includes antioxidant lutein esters which recent studies have linked to reduced risk of age related macular degeneration.

Eye-catching new packaging will be introduced for the supplement.

The relaunch will be supported by a £0.5 million press and London Underground advertising campaign.

Price: £6.95

Pack size: 30 tablets
Pip code: 290-9448
Vitabiotics Ltd
Tel: 020 8902 4455.

Myoplex makes sense of carbohydrates

EAS is rebranding its low carbohydrate nutrition bar as Myoplex Carb Sense.

The high protein bar is being introduced in two new flavours – Cookies and Cream, and Chocolate Dipped Strawberry – in addition to the existing Blueberry, Apple Cinnamon and Lemon variants.

The bar contains whey protein and around 6g of fat per bar, depending on flavour.

It also delivers 1-3g of 'impact carbs' – carbohydrates said to have an impact on the body's insulin and blood sugar levels.

The bar can be eaten as a high protein snack or as a post-workout source of nutrition for those who do not have time to prepare a meal and then sit down to eat it.

Price: £2.49

Pack size: 70g
Health & Diet Food Co
Tel: 01204 702121.

Three steps to pure skin

L'Oreal Paris is launching a three-step purifying skincare range especially for young and problem skin.

L'Oreal Dermo-Expertise Pure Zone is a range of five products designed to control blemishes and keep skin clear and well hydrated.

Step 1 includes three deep purifying products – Deep Exfoliating Gel Wash, Deep Purifying Gel Wash and Daily Deep Cleansing Foaming Cloths.

Step 2 is Pore Tightening & Clarifying Lotion and Step 3 is Anti-Regreasing Moisturiser.

The range is formulated with Sebo-Calmyl, an extract derived from a natural marine botanical, and salicylic acid to help regulate sebum production and eliminate dead skin cells.

The products also contain anti-shine agents including clay and silica to help absorb excess sebum, leaving skin fresh and matte.

Price: gel wash and lotion £4.99; cloths and moisturiser £5.99

L'Oreal Group UK
Tel: 020 8762 4000.

Cough, cold & flu FORECAST

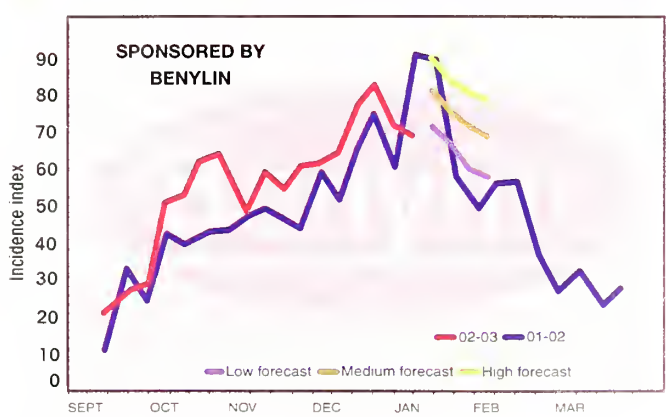
Cities on Pre-Alert
Cities on Advisory

KEY FACTS

Benylin

- The entire UK continues on Cold and Flu Alert.
- 1 in 8 of the population are suffering from cold and flu symptoms.
- Cough, body ache and low fever are amongst the most prevalent symptoms.

Information updated weekly by SDI



Time to check your stock levels!

Frontshop

Wella turns heads on Red Nose Day

Wella has pledged to raise £300,000 for Comic Relief as the official hair partner for Red Nose Day 2003 on March 14.

Pharmacies can help raise the money by participating in the Wella Comic Relief promotions during February and March.

For every unit of Red Nose Day-stickered Wella Shockwaves, Wella Vosene and Wella Silvikrin sold during the Comic Relief fundraising period, Wella will donate 20p to charity.

The company has also produced a Comic Relief Scratch & Match sweepstake poster. The idea is to get staff and customers to pay £1 to guess the hairstyle of the celebrity on the poster. On Red Nose Day, once everyone has chosen one of 40 styles available, the silver panel above the celebrity's head can be scratched off to reveal the winning hairdo. The winner pockets half the money and the other half is donated to Comic Relief.

For more information:
Wella Great Britain
Tel: 01256 376175.

The sky's the limit for Rimmel's new colours

Rimmel is launching a limited edition cosmetics collection for spring.

Rimmel's Sky Rise Spring 2003 collection will feature soft pastel shades to complement key new fashion trends for the coming season.

Three new Special Eyes Duo Eyeshadow powder palettes will each team a matte pastel shade of pink, green or sky blue with the subtle and delicate shimmer of a co-ordinating white tone.

Shine Temptation Lipstick and 60 Seconds Nail Polish will both be available in three new shades of pink.

Price: duo eyeshadow and lipstick £4.49, nail polish £2.89

Coty (UK) Ltd
Tel: 020 8971 1300.

A place in the sun at L'Oreal skincare

L'Oreal Paris is launching a suncare range designed to combine its skincare and sun protection technologies.

The Solar Expertise range contains Activa-Cell which L'Oreal says stimulates the different cellular processes to reinforce the skin's natural self-repair and defence mechanisms.

The products are formulated to be non-sticky, non-greasy and pleasant to use.

The sun protection range includes three very high protection products for fair, sensitive skins (SPF 60-40), four high protection products for lightly tanned or natural olive skin (SPF 30-20) and four medium protection products for sun tanned or natural golden skin (SPF 15-8).

All the suncare products contain Mexoryl SX and Mexoryl XL to absorb both UVA and UVB rays.

Completing the range are three after-sun products – Rehydrating Soothing Milk, Refreshing Creme Gel and Soothing Facial Moisturiser.

Price: from £8.00 for soothing milk to £15.00 for protection spray SPF 20 and 30

L'Oreal Group UK
Tel: 020 8762 4000.

A clean sweep for Clearasil

Crookes Healthcare is kicking off the New Year with TV advertising for the recently launched Clearasil Complete Deep Cleansing Body Wash.

A new commercial for the teen skincare brand will be aired on top teenage programmes from January 13 until the end of February.

Advertising has been created to raise awareness and generate trial of the brand's body wash product.

The TV burst is part of a £4.2 million advertising campaign for the Clearasil brand this year.

For more information:
Crookes Healthcare Ltd
Tel: 0115 953 9922.

TV next week

Bassett's Soft & Chewy Vitamins: GMTV, C5, Sat
Benylin: All areas except U
Breathe Right Nasal Strips: All areas except CTV
Califig: C4
Clearasil Body Wash: All areas except GMTV
Covonia: TT, GMTV, C5, Sat
Imodium: All areas
Just for Men: All areas
Kalms: C5, GMTV, Sat
Nicotinell: All areas
NiQuitin CQ: U
Nivea After Shave Balm: All areas
Nivea Lip Pearl & Shine: All areas
Olbas: C5, GMTV, Sat
Pepcidtwo: All areas except CTV, TSW
Seabond: All areas
Seven Seas Pure Cod Liver Oil: C4
Seven Seas Neutrataste: ITV
Sudafed Non-Drowsy: All areas except U, GMTV
Throaties: GMTV, Sat

PharmaSite for next week: Niquitin – Window, **Niquitin** – In-store, **Zovirax** – Dispensary

A-Anglia, B-Border, C-Central, C4-Channel 4, C5-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

STILL No. 1.
WITH 6,000,000 REASONS
WHY WE'LL STAY THERE.

Yet again, Seven Seas finished the year top of the CLO sector. And for 2003, we will be investing even more - increased support for established products and more investment in new ideas. **With £6,000,000 to put behind marketing this year – including a national TV campaign in January and February** – demand will stay high. So follow the leader – stock up now.

SEVEN SEAS®

BUILDING MARKETS · BUILDING BRANDS

Frontshop

Banishing kids' bedtime blues

Kimberly-Clark is investing £1 million in marketing support for the rebranding of the company's DryNites absorbent pants in February.

The product has been renamed DryNites Pyjama Pants to convey the nightime usage occasion and to emphasise that it is a specially designed absorbent pant and not a nappy.

Designed to wear under nightclothes, the pants pull up and down like underwear. They are available in three sizes for children aged 4-7 (medium), 7-10 (large), 10-15 (extra large).

Colourful new packaging has been designed to make the pants more appealing to children and less medical in their appearance.

The rebranding will be supported by TV advertising, direct mail and sampling.

For more information:

Kimberly-Clark Ltd
Tel: 01732 594000.

Inbrief

Acriflex change

Thornton & Ross has acquired Acriflex chlorhexidine-based antiseptic cream (0.25 per cent) from SSL International. Acriflex is indicated for minor burns, scalds, scratches, cuts and abrasions, sunburn, blisters and infected, cracked skin.

For more information:

Thornton & Ross
Tel: 01484 842217.

Tune in to Zovirax

GlaxoSmithKline is supporting Zovirax Cold Sore Cream with a radio campaign for the first time. Running until February 9, the campaign is designed to reach 16-34 year olds prior to social outings in the evening.

For more information:

GlaxoSmithKline Consumer Healthcare UK
Tel: 020 8047 5000.

Aussie promotion

Numark Trading is running a promotion with Procter & Gamble offering the chance to win a fortnight's holiday for two in Australia.

To enter, customers will need to purchase two products from the Aussie Haircare range and complete the competition leaflet. Closing date is February 28.

For more information:

Numark Trading Ltd
Tel: 01827 841200.

Supplement for slimmers

US supplement manufacturer Cytodyne Technologies has launched a supplement designed to offer slimmers a natural approach to weight control. Xenadrine-EFX is a blend of herbal extracts, antioxidants, minerals and amino acids.

Price: £39.95

Pack size: 120 capsules
Micro Tech International (UK) Ltd
Tel: 01403 732427.

ICaps® focuses on Healthy Eyes

Alcon®, the world's largest eye care company, announces the launch of ICaps Dietary Supplement into pharmacy.

Providing essential antioxidants found in healthy eyes and a balance of the eye-carotenoids, Lutein & Zeaxanthin, and other multivitamins and minerals, ICaps is recommended for people at risk from Age-related Macular Degeneration (AMD.)

Risk factors for AMD include:

- Age (above 40)
- Gender (higher risk in women)
- Diet & nutrition
- Sunlight (light-coloured eyes are more prone to damage)
- Smoking
- Cardiovascular disease
- Heredity (Family history)

ICaps tablets provide the necessary nutrients to maintain healthy eyes and good visual function. Already recommended by Ophthalmologists and Opticians, ICaps has two unique features that set the supplement apart from other specific eye care supplements:

- ICaps is the only ocular supplement found to have the same nutrient bioavailability equal to four servings of vegetables and fruits per day[1]
- A sustained release formula, for improved absorption and less stomach irritation, which is common in the elderly and with high levels of zinc.

ICaps and AMD

Lutein and Zeaxanthin are natural carotenoids, which have been shown through structural and clinical studies to be concentrated in the macular segment of the retina. The body cannot make these carotenoids so accumulation is dependent upon dietary intake. Studies have demonstrated a relationship between dietary carotenoids and the maintenance of a normal healthy macula which is correlated with clarity of the lens of the eye[2]. Lutein & Zeaxanthin exist mainly in green vegetables such as spinach, cabbage and broccoli, but it is not always practical to consume these foods in the amounts recommended. The required amounts can easily be obtained from a daily dose of ICaps.

What is AMD?

Age-related macular degeneration (AMD) is the leading cause of irreversible vision loss in people over 65 in the Western World. It is believed that the number of cases have doubled since the 1950s and is likely to treble over the next 25 years.

AMD occurs when cells in the macula degrade resulting in the loss of central vision, leaving peripheral vision intact, subsequently leading to difficulty with reading, writing and even driving.

In the UK, AMD accounts for 55% of registered blindness. Research shows that as many people again could be registered as blind or partially sighted if they chose to do so. It is believed that at least 300,000 people are suffering from severe sight loss through AMD.[3]

A growing body of research suggests that nutrition plays an important role in AMD. Improving daily diet may slow deterioration from AMD and may reduce blurriness and enhance overall vision. More importantly, diet may help delay or prevent the onset of the condition.

The Age Related Eye Disease Study (AREDS) using a combination of antioxidant vitamims plus zinc, carried out on 3,640 patients over an average of six years, highlighted a 25% reduction in progression to advanced AMD.[4]

A study sponsored by the National Institute of Health in the USA found that people who ate five or more servings of foods rich in Lutein & Zeaxanthin lowered the risk of developing AMD by 43%.[5]

Promotional Support

The launch of ICaps into pharmacy is being supported by Alcon with an educational and promotional campaign targeting both pharmacists and consumers.

Prices ICaps from Alcon are available in one-month packs of 60 tablets. RRP £9.95.

Ordering Details

ICaps can be ordered from major wholesalers.

For further information

Call the Alcon information line on freephone

0800 092 4567

www.luteininfo.co.uk

ICaps is not recommended for children or in pregnancy

References:

1. Bernstein P, et.al. Comparison of Ocular Antioxidant Supplements and Diet, University of Utah
2. Pratt S. – Journal of the American Optometric Association 1999; 70;39-47
3. The Macular Disease Society
4. AREDS, Arch Ophthalmology, vol 119 No. 10, Oct 2001
5. Seddon J, et.al. Journal of the American Medical Association, 1994; 272:1413-20

We should not underestimate the impact that smoking has on the health of those who persist despite all the warnings. Dr Terry Maguire says it's time to consider a harm reduction approach

Reaching the diehard

Smoking cessation is understandably a key aspect of public health policy in most developed countries. The health gain from reducing the prevalence of smoking within the population is clear cut. Half of all smokers who continue to smoke will die from their habit and half of those who die do so before the age of 60. So stopping smoking makes good sense.

This year 8,000 people will die in Ireland as a result of smoking related diseases. Smoking related illnesses present a huge burden to the economy – for example it costs the UK €2.5 billion annually.

Getting people to stop smoking is not easy and it's even more difficult to get them to stay off it. Mark Twain's quip: "It's easy to stop smoking – I've done it 50 times," sadly rings true.

Smoking cessation initiatives do bring success. Brief intervention from, for example, GPs, has been shown to be effective and greater success is associated with more intense programmes such as those provided by pharmacists, nurses and in smoking cessation clinics.

Nicotine replacement therapy (NRT) also works and when used alone or within a smoking cessation programme doubles the chances of success. So it makes senses to use NRT as widely as possible. There is no good evidence that any particular formulation of NRT is better than any other, therefore it's best to use the product that suits the smoker.

But are we really doing enough to help smokers stop and therefore reduce the burden of smoking-related illnesses? When so few smokers are attempting to stop each year and fewer still are abstaining for more than 12 months, what more could be done?

It seems somewhat ironic that NRT products need to go through the full rigours of drug licensing and, as a consequence, have restrictions on their use imposed where tobacco products have none. Licensing restrictions severely limit the use of NRT. For example, most healthcare professionals appear reluctant to recommend or prescribe NRT for pregnant smokers, those under 18 years of age and those who have used the product for 10-12 weeks (recommended treatment period). Worse still, some pharmacists and GPs consider chronic diseases such as diabetes, coronary heart disease and other circulatory diseases as contraindications to NRT use.

As healthcare professionals and policymakers we have perhaps adopted an extreme and puritanical approach to smoking and the need for all smokers to stop. There is no doubt that cessation is the ideal scenario but it fails to appreciate the complex addiction that is cigarette smoking. Our approach may not serve the needs of many smokers, especially those who cannot or do not wish to stop.

"It seems ironic that NRT products... have restrictions on their use imposed where tobacco products have none"

If we really want to do more for smokers, it's time to consider a harm reduction approach towards nicotine use in society to complement our smoking cessation policy. For smokers, the addiction is to nicotine, yet nicotine is not the hazard to health that comes from other chemicals produced by burning tobacco.

The main problem is the means by which nicotine is delivered to the brain. Cigarettes are nicotine delivery systems. They are similar to the hypodermic syringe in heroin abuse but in the case of cigarette smoking, the hypodermic syringe is a dirty one containing some 4,000 chemicals, many of which are highly toxic.

Therefore other ways of delivering nicotine from tobacco are associated with less harm. Snus, a form of chewing tobacco in a pouch, is widely used by men in Sweden – about half of all tobacco users use it. This reflects a much lower incidence of smoking-related illnesses in Sweden compared to other European countries. So is it time for a tobacco harm reduction policy?

Harm reduction has been used in other areas with considerable success. The term harm reduction refers to strategies for reducing the physical and social harm associated with risk-taking behaviour. Examples include needle exchanges, purity standards for alcoholic beverages and safety glass in vehicle windscreens. When it proves difficult to prevent harmful behaviour it may be possible to reduce the harm done. For those unable or unwilling to stop using nicotine we can offer a product and regulatory approach that supports (or does not inhibit) users switching to less harmful forms of nicotine.

"The tobacco industry may be poised... to market 'safe' tobacco products in Europe"

The tobacco industry may be poised to exploit this fact and to market 'safe' tobacco products in Europe. Such products already exist – the most novel being Nicowater (nicotine in water) – and are being marketed in the USA. Of course, this is highly unethical but then ethics have never been a big issue within the tobacco industry.

There have been government efforts, especially in the USA, to apply regulatory controls to tobacco products and in doing so reduce the harm they cause. This nearly succeeded in the 1990s when the Food and Drugs Administration (FDA) attempted to apply restrictions on cigarettes and other tobacco products.

For example, the FDA wanted to control the concentrations of certain chemical toxins in tobacco. Such a move, no matter how well intentioned, might have the effect of endorsing the 'safety' of tobacco to the public. Smokers may then feel that there is no need to stop smoking. No doubt the tobacco industry would see huge marketing benefits from such regulation.

But we already have a safe form of nicotine in the NRT products developed and licensed by the pharmaceutical industry. By simply widening the product licence indications for NRT products we could support a harm reduction strategy for tobacco.

The difficulty is that the currently licensed NRT products do not deliver nicotine to the brain in the way that many smokers want. A puff of a cigarette will deliver a high dose of nicotine to the brain in about seven seconds. It is this rapid delivery rate of a high dose that is central to the 'positive' aspects of smoking. This nicotine hit is what smokers want. NRT products are formulated to provide a background blood level of nicotine, thus reducing the cravings from withdrawal of nicotine – the 'negative' aspect of smoking.

NRT supports smokers during cessation until they learn to do without smoking. But there is good evidence that NRT use in some ex-

smoker

smokers can go on for longer periods of time and therefore act as a replacement for smoking – an alternative form of nicotine use.

A harm reduction policy for tobacco needs to be discussed and debated but must not be ignored – cigarettes cause too much damage to health. The Government needs to consider whether it will sanction such a policy rather than leave it to the tobacco industry to cynically fill this vacuum.

Before this, however, all healthcare professionals need to consider if they are doing enough to motivate, educate and facilitate patients in quitting smoking and remaining quitters. Smoking cessation must not be a bolt-on to the professional service we provide but must be an implicit part of our practice. It is unethical to ignore smoking, as the patient's condition is unlikely to improve until they stop. As pharmacists, doctors and nurses committed to patient care we need to consider the smoking status of all our patients when they meet us.

When a patient presents with hypertension and that patient is a smoker then the single most important factor to address is the smoking. When a patient presents with diabetes and that patient is a smoker the single most important issue to address is the smoking. Smoking is *that* important and we need to consider if we are doing enough to reduce its effect on public health.

Dr Maguire is a community pharmacist in Belfast. He is vice-chairman of the Pharmacy Healthcare Scheme, a UK charity which promotes health and wellbeing to the public through pharmacies. He is also a member of the Committee on Safety of Medicines – the UK body responsible for the regulation of pharmaceutical products.

Rave on

As the local drug expert, what do you know about special K, liquid X and forget-me pills, asks Gary Paragpuri

After Travolta and Thurman's drug-fuelled gyrations in the movie *Pulp Fiction*, it is not surprising that illicit drug use has attracted a certain kudos among the younger generation.

In fact, nearly 30 per cent of 16 to 24 year-olds used illicit drugs in 2000, according to UK Government figures. The most popular drugs were cannabis, amphetamines, ecstasy, cocaine, LSD, glue, crack and heroin.

And despite all the media scare stories, such as the grim newspaper photographs of Leah Betts and Lorna Spinks, who both died after taking ecstasy in 1995 and 2001 respectively, millions of people continue to use recreational drugs every weekend. As a result, there may well be a need for an accessible source of drug information for users, whether or not healthcare professionals agree with it.

Earlier this year, a review of 'rave drugs' in the *American Journal of Health-System Pharmacy (AJHSP)* concluded that pharmacists should be on guard to recognise and manage serious reactions from such substances.

In particular, it highlighted the increasing abuse of methylenedioxymethamphetamine MDMA (ecstasy), flunitrazepam (forget-me pills), ketamine (special K) and gamma-hydroxybutyrate (liquid X).

According to Glen Hanson, acting director of the US National Institute on Drug Abuse, there is now substantial evidence demonstrating that these drugs are not benign. Speaking before the US Senate, he said: "While users of club drugs often take some of these drugs for energy to keep on dancing or partying, research reveals these drugs can cause long-lasting negative effects on the brain, altering memory and other behaviours."

Mr Hanson added that club drugs are rarely used alone. It is 'polydrug' use, especially among younger users, which appears to be the norm, he said. "It is not uncommon for users to mix substances such as MDMA, for example, with both alcohol and GHB, or to 'bump' and take sequential doses of a drug or drugs when the initial dose begins to fade."

Club drugs first gained popularity with the advent of all-night 'rave parties' in Europe in the 1980s, says the *AJHSP*. The substances, which have now established themselves across the USA, heighten the user's party experience by decreasing inhibitions and increasing the energy for dancing for longer periods.

"Most users consider these agents to pose few if any safety risks, but the frequent arrests, serious reactions and emergency department visits associated with their use suggest otherwise," says the journal. The *AJHSP*'s clinical review centres on the following four drugs:

MDMA was first synthesised in 1914 in Germany, and was used as an appetite suppressant. It is available in a variety of

"Pharmacists should be on guard to recognise and manage serious reactions from such substances"

forms including capsules, powder and tablets. The latter, which are available in a variety of colours, usually contain about 50mg-150mg of the drug, and are often imprinted with icons such as the Nike swoosh, the Motorola logo, smurfs or butterflies.

MDMA produces both hallucinogenic and stimulant effects. It increases the release of serotonin, dopamine and noradrenaline, and prevents their metabolism by inhibiting monoamine oxidase. The excess dopamine and serotonin is believed to be responsible for the hallucinogenic effects, which appear about 30 to 60 minutes after ingestion. These effects, which include feelings of euphoria and intimacy, altered visual perception, enhanced libido, increased energy, a rise in body temperature, and diminished hunger and thirst, can last up to eight hours.

Dancing for long periods worsens the effects by exacerbating both hyperthermia and dehydration. Although there are many adverse effects, the most common symptoms with which patients present at A&E are agitation, anxiety, tachycardia and hypertension. Treatment generally involves activated charcoal to absorb any drug from the GI tract, and supportive care including benzodiazepines, labetalol and phentolamine to control agitation and hypertension. In cases of hyperthermia, rapid cooling is necessary. But as the resultant shivering generates further heat, a neuromuscular blockade to prevent shivering is also administered.

Flunitrazepam, which is marketed as Rohypnol, is 10 times as potent as diazepam. This coupled with its relatively low price, makes it popular among teenagers as a cheap 'high'. At low doses it acts as an anxiolytic, muscle relaxant and sedative, but higher doses result in a lack of muscle control and loss of consciousness.

However, it is rarely taken on its own, and is more likely to be used with cocaine and heroin. Co-administration with alcohol leads to amnesia and loss of inhibitions. The effects are fairly rapid, with sedation and amnesia occurring within 30 minutes, and doses as little as 1mg can impair individuals for up to eight hours. Adverse effects include hypotension, dizziness, confusion, visual disturbances, urinary retention and aggression. The management of patients who have taken flunitrazepam is generally supportive in nature. Charcoal and gastric lavage can be used if other drugs have been taken as well, and flumazenil, a benzodiazepine antidote, can be administered.

Ketamine was introduced in the 1960s as an anaesthetic, but has generally been replaced with safer and more effective products. Although it is only manufactured clinically as an injection, powder and tablet formulations are also available on 'the street'. Ketamine is tasteless, odourless and colourless, and is usually injected, smoked or snorted. It has a rapid onset of action and lasts for about 45 minutes. While lower doses produce analgesia, higher amounts lead to effects such as 'out-of-body' experiences, hallucinations and a lack of co-ordination. As well as causing cardiovascular and respiratory toxicity, patients who use ketamine may develop confusion, hostility and delirium, and habitual users risk developing severe addiction.

Ketamine is fast acting. In cases where drinks have been spiked, victims can develop amnesia within 15 minutes and due to the vivid hallucinations produced it can become difficult to differentiate between drug-induced effects and reality. In managing patients, again supportive care rather than a specific antidote is the treatment of choice. Patients can be sedated with midazolam, and, if required, hallucinatory effects can be reduced by placing patients in an area with reduced stimuli.

Gamma-hydroxybutyrate (GHB) is naturally occurring. It is an endogenous metabolite of the CNS neurotransmitter, gamma-aminobutyric acid (GABA). In the past, GHB has been used in the management of narcolepsy, and has been tested for the promotion of muscle development, treatment of alcohol and opiate dependence, weight control and schizophrenia. It is thought to exert its effects by acting upon body temperature, memory and cerebral glucose metabolism.

"It is often a cocktail of chemicals that is responsible for most drug-related deaths"

However, its purported ability to control sleep cycles is the main reason for its abuse. Bodybuilders believe that by using GHB, which is thought to prolong slow-wave sleep – the peak period for growth hormone release – they can aid muscle development. Despite a lack of evidence to substantiate these claims, it remains a drug of abuse.

Recreational users take GHB for its CNS depressant effect, to counteract the effects of stimulatory drugs, such as ecstasy. But its effects are potentiated by benzodiazepines, alcohol and opiates. At higher doses, CNS depression progresses to amnesia, dizziness, euphoria, seizures and death. The margin separating the euphoric effects from death appears to be slim. Seizures, coma and death have been associated with doses exceeding 50mg per kg.

Again, no specific antidote exists, and treatment is usually supportive for patients, who normally recover within about seven hours after receiving treatment. Because GHB causes rapid loss of consciousness, gastric lavage and induction of emesis are contraindicated. Bradycardia symptoms can be managed with atropine, and seizures with benzodiazepines, but despite the fact that GHB intoxication resembles benzodiazepine overdose, flumazenil does not help.

As stated earlier, however, it is often a cocktail of chemicals that is responsible for most drug-related deaths. Some of these chemicals are well known and their effects are extensively documented, while others are less well known, leading to treatment delays. In some cases authorities only find out about the latest drug after a patient presents with symptoms of toxicity.

In a bid to provide healthcare professionals with the most up to date information, Dr Fabrizio Schifano from St George's Hospital Medical School in London, is constructing a map of drug-related websites. He will collect data from websites relating to the design and sale of illicit substance, with the aim of providing healthcare professionals with information on the latest drugs.

"We will identify emerging trends in new drugs and mixtures of drugs at the regional European level," says Dr Schifano.

"An early warning system will also be developed by collecting data on the virtual drugs market. We hope this will help ease public health threats linked to the newest drugs."

For more information: www.ashp.org, Am J Health-Syst Pharm 2002; 59: 1067-76

Rising death rates

- The number of deaths caused by drugs of abuse is on the increase, according to a report by the European Centre for Addiction Studies.
- *Drug-Related Deaths as Reported by Coroners in England & Wales* shows that there were 1,498 drug-related deaths in 2001, compared with 1,296 in 2000.
- Heroin/morphine is implicated in the majority of eases (39 per cent) but this figure is an 8 per cent decrease on the previous year.
- However, there were large increases in deaths due to other drugs of abuse, including 95 cocaine-related deaths, 33 amphetamine-related deaths and 43 ecstasy-related deaths – rises of 42, 57 and 26 per cent respectively.
- Brighton & Hove remains the area with the highest annual death rate (28 per 100,000 population over the age of 16).

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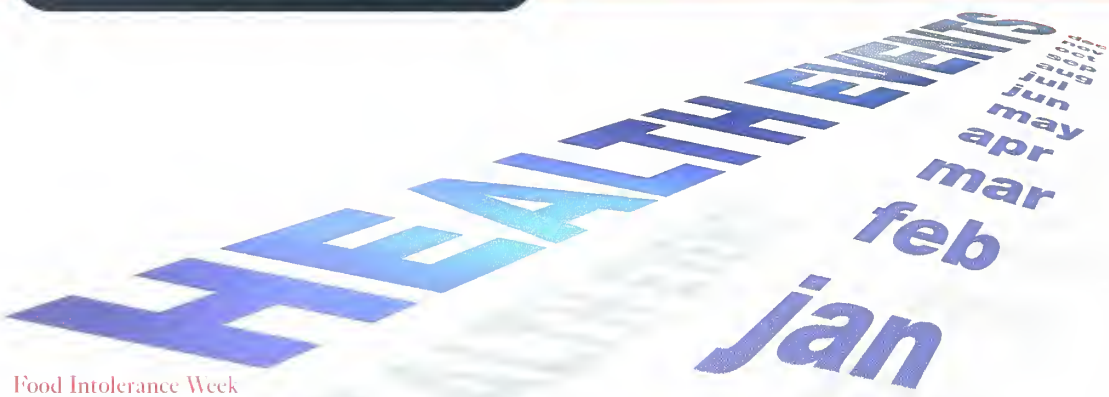

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www.nits.net/bugbusting

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www.raynauds.demon.co.uk

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Tel: 01603 621414
www.edauk.com

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www.fpa.org.uk

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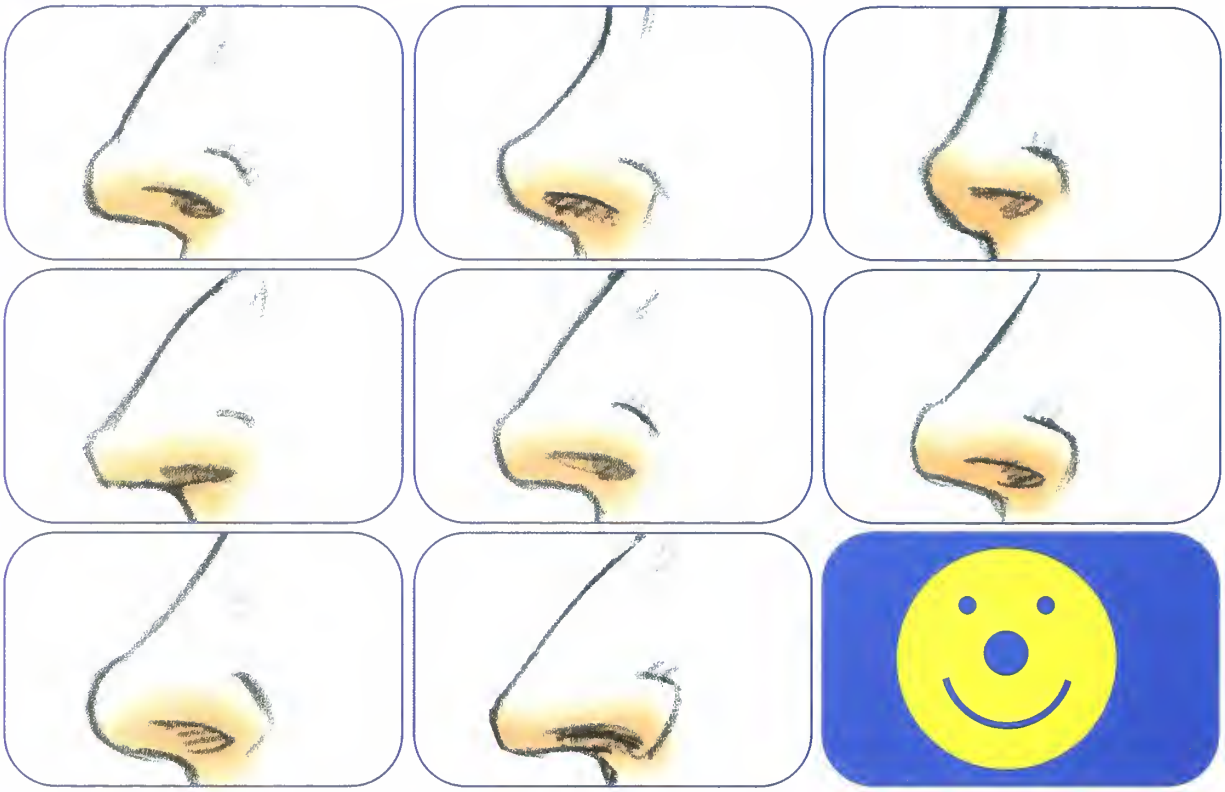

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